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EARLY DIAGNOSIS AND MISTAKEN
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OF THE BREAST.

BY
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OF DENVER, COL.

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EARLY DIAGNOSIS AND MISTAKEN DIAGNOSIS IN CASES OF TUMOR OF THE BREAST.¹

BY CHARLES A. POWERS, M.D.,
OF DENVER, COL.

THE frequency with which the female breast is the seat of a tumor is well known to all practitioners of medicine, but the difficulties attending accurate diagnosis are appreciated only by those who see many of these cases ; and as correct diagnosis forms the key-note to successful management and favorable prognosis, I have felt that a recital of some of my own errors might be of value to others.

A study of cases in which the histologic condition has been at variance with the clinical diagnosis has been of much interest, and has served to impress on me the wide range of variation in symptoms which these mammary tumors present, and the ease with which malignant growth may be considered benign, or a benign growth be thought malignant. Of such vast importance in the management of malignant growth of the breast is early diagnosis that too much stress cannot be laid on the principle that every lump or nodule in the gland is to be explored unless there be some distinct contraindication; such contraindication will rarely be found. Women are prone to overlook these lumps or to conceal them, and all surgeons know how frequently they appear with a mammary tumor, which, perhaps, is as large as one's

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fist. The remedy for this, so far as a remedy may be found, lies in impressing on the laity the fact that all lumps and growths are important, no matter how small they may be, and that competent advice thereon should be sought at the earliest possible moment. Physicians can do much in this way; they should lose no opportunity of informing their patients that all bunches and growths ought to be attended to, and that the benign tumor of to-day may be malignant in the future. Only too often does the family practitioner, when shown a lump in a woman's breast, say that it is unimportant, and that he will look at it again in a month or two. The woman's fears are allayed, she neglects to again call the physician's attention to the matter, and when she does seek advice the growth is very probably beyond possibility of cure. During the past month two such patients have come to my office. In each the family physician had advised delay until the growth had become large, and then had removed only the breast. When coming under observation each scar was the seat of inoperable recurrence.

To many of us these are trite words, but every surgeon knows how often unwise delay or incomplete operation leads to a speedy and fatal termination, and I feel that these principles cannot be repeated too frequently or impressed too strongly. Successful management of malignant disease may to-day be summed up in these words: Early recognition, early and thorough operation, and careful surveillance of the patient for many years afterward. Progress in this direction is steadily being made, and the future

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undoubtedly has in store for us results which now seem impossible of attainment.

For some years it has been my custom to enter in my case-book the provisional clinical diagnosis of a given tumor and to place opposite this, after operation, the result of the microscopic examination of the growth. These parallel columns not infrequently differ materially. Permit me to cite some of the errors:

CASE I.—Mrs. S., thirty-five years of age, was referred to me March 5, 1892, by Dr. Geoffrey R. Bourke. For some months she had noticed a small lump in the upper, outer quadrant of the left breast. This mass was about the size of a robin's egg, somewhat flattened, rounded, freely movable, and the skin over it normal, the nipple not being affected. There was nothing to be felt in the axilla or in the supraclavicular space. The "feel" of the tumor seemed to be that of a fibro-adenoma, and the patient and her husband were advised that the growth was probably benign, but that it possibly might be found to be malignant. Their consent was obtained to a complete operation in case it was thought advisable. On cutting into the growth it seemed to be malignant, and the breast, pectoralis major muscle, and axillary contents were excised. Microscopic examination of the growth proved it to be a medullary carcinoma. One small malignant gland was found in the axillary fat. The patient had a secondary mass removed two years later and died of internal recurrence at the end of three years.

CASE II.—This case was similar to the foregoing, except in that the mammary lump, which was the size of an almond, seemed to be so certainly benign that it alone was removed. The microscope showed it to be carcinoma, whereupon the "complete"

operation was performed. There were two or three small malignant glands in the axilla. This patient is free from recurrence, and it is now more than five years since her operation. She was thirty-two years old at that time.

CASE III.—Mrs. X., forty years of age, was referred to me during June, 1893, by Dr. T. T. Janeway of New York. For some months she had noticed the progressive growth of a lump in the right breast. Examination revealed an irregular mass the size of an apple in its inner, upper quadrant. This mass was deep seated; it seemed to be hard and partially fixed. Provisional diagnosis of carcinoma was made. At the time of operation an incision was made into the mass, and it was found to be a simple cyst. This alone was dissected out.

CASE IV.—This was another instance of the same error. The patient, a woman thirty-eight years of age, was referred to me by Dr. Jas. A. Hart of Colorado Springs during February of the present year. A week before I saw her she first noticed a mass the size of a small fist in the upper, inner quadrant of the right breast. She at once showed this to Dr. Hart, who pronounced it cancer and immediately sent her to me for operation. On careful examination I could not doubt that the growth was malignant. It was hard, nodular, and non-fluctuating; it seemed to be carcinoma. At the time of operation incision into it revealed a large, irregular cyst. This was dissected out. At one or two places the cyst wall seemed to be hard and suspicious-looking, and Dr. H. C. Crouch, who was present, examined it microscopically, but failed to find evidence of malignancy.

In each of these instances incision into the tumor at the time of operation revealed the cystic nature of the growth. The exploring needle before

operation would have shown as much, but the diagnosis seemed so fairly certain that I did not make use of it. We are not to forget that cysts and abscesses sometimes are mistaken for malignant growths and an entire gland needlessly sacrificed. I myself came very near doing this in Case V., in which a mass, which I thought was probably carcinoma, proved on incision to be a hematoma (New York Cancer Hospital), and in another (Case VI. of the present series), in which I mistook tuberculosis of the breast for cancer. Fortunately, the entire breast was not sacrificed in the first of these instances, though it was deliberately removed in the second. I was not so fortunate, however, in Case VII., for in this I removed the breast and axillary contents for a small lump, which seemed at the time of operation to be carcinoma, but which the microscope showed to be a fibro-adenoma. Some of you may remember that I reported the case to this Society some eighteen months ago, contrasting it with another in which a small lump, which seemed at the time of operation to be benign, proved to be malignant, and I was obliged to return and complete the removal of the breast, pectoralis major muscle, and axillary contents. Added cases have served to impress upon me the value of a microscopic examination of uncertain, or, indeed, of fairly certain, tumors at the time of operation. This consumes but a few moments, perhaps eight to twelve minutes, and may be of great diagnostic value. So, when a tumor, which we think to be benign, is found by the pathologist to be malignant, our course is clear, while if he fails to find evidence of malignancy we are justified, in ordinary

cases, in removing the growth itself, submitting it to him for thorough examination, and being governed by his final report as to further procedure.

True, there are many breast tumors in which we need no evidence in addition to the clinical signs, indeed, the majority fall in this category, but there are many in which we require all possible aid. An excellent illustration of this, though in another part of the body, came under my observation a few weeks ago. A young man, twenty-six years of age, came to me with a small tumor of the parotid, which I thought, without doubt, was benign. I removed it and sent it to Dr. Crouch, who pronounced it myxomatous carcinoma, whereupon I was forced to return and remove the entire parotid gland and the adjacent tissues. In passing, it may be said that Dr. C. B. Porter, who wrote the excellent article in Dennis' "System of Surgery," says of these parotid tumors: "The diagnosis, and the decision to attempt removal of the tumor only or of the whole gland, should be controlled by the microscope at the time of operation, when possible."

Exceptional lumps in the breast may warrant delay and watching, but this delay is not to be made without careful thought and study. I have seen three instances of what Mr. Herbert Snow calls "Dispersible Tumors of the Breast," lumps which disappeared in a few weeks or months. One of these was in a little girl seven years of age, from whose mother I had removed a fibro-adenoma of the mamma.

Such admirable papers have been recently published by Bull, Richardson, Warren, Halsted, and

others, that I refrain from speaking of the provisional differential diagnosis and management of mammary neoplasms, and content myself with endeavoring to impress upon you the absolute importance of the earliest possible attention in such cases, as well as my own conviction, a conviction based on the operative care of some ninety patients with breast tumors, that accurate clinical diagnosis is often difficult, and, indeed, at times impossible.

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